R590. Insurance, Administration.
R590-203. Health Grievance Review Process.
R590-203-4. Definitions.

In addition to the definitions in Section 31A-1-301, the following definitions shall apply for the purposes of this rule:

(1)(a) "Adverse benefit determination" means the:

(i) denial of a benefit;

(ii) reduction of a benefit;

(iii) termination of a benefit; or

(iv) failure to provide or make payment, in whole or in part, for a benefit.

(b) "Adverse benefit determination" includes:

(i) denial, reduction, termination, or failure to provide or make payment that is based on a determination of an insured's eligibility to participate in a plan;

(ii) a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for, a benefit resulting from the application of a utilization review; and

(iii) failure to cover an item or service for which benefits are otherwise provided because it is determined to be:

(A) experimental;

(B) investigational; or

(C) not a medical necessity or appropriate.

(2) "Carrier" means any person or entity that provides health insurance or disability income insurance in this state including:

(a) an insurance company;

(b) a prepaid hospital or medical care plan;

(c) a health maintenance organization;

(d) a multiple employer welfare arrangement; and

(e) any other person or entity providing a health insurance or disability income insurance plan under Title 31A.

(3) "Consumer Representative" may be an employee of the carrier who is a consumer of a health insurance or a disability income policy, as long as the employee is not:

(a) the individual who made the adverse determination; or

(b) a subordinate to the individual who made the adverse determination.

(4) "Medical Necessity" means:

(a) health care services or products that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:

(i) in accordance with generally accepted standards of medical practice in the United States;

(ii) clinically appropriate in terms of type, frequency, extent, site, and duration;

(iii) not primarily for the convenience of the patient, physician, or other health care provider; and

(iv) covered under the contract; and

(b) that when a medical question-of-fact exists medical necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and known to be effective.

(i) For interventions not yet in widespread use, the effectiveness shall be based on scientific evidence.

(ii) For established interventions, the effectiveness shall be based on:

(A) scientific evidence;

(B) professional standards; and

(C) expert opinion.

(5)(a) "Scientific evidence" means:

(i) scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or

(ii) findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes.

(b) Scientific evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

(6)(a) "Urgent care claim" means a request for a health care service or course of treatment with respect to which the time periods for making non-urgent care request determination:

(i) could seriously jeopardize the life or health of the insured or the ability of the insured to regain maximum function; or

(ii) in the opinion of [~~the insured's attending provider~~]a physician with knowledge of the insured's medical condition, would subject the insured to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

(b)(i) Except as provided in Subsection (6)(a)(ii), in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

(ii) Any request that a physician with knowledge of the insured's medical condition determines is an urgent care request within the meaning of Subsection (6)(a) shall be treated as an urgent care claim.

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